CANNON BUILDING
861 SILVER LAKE BLVD., SUITE 203
DOVER, DELAWARE 19904-2467

**STATE OF DELAWARE**

**BOARD OF EXAMINERS IN OPTOMETRY**

TELEPHONE: (302) 744-4500
FAX: (302) 739-2711
WEBSITE: DPR.DELAWARE.GOV
EMAIL: customerservice.dpr@state.de.us

# APPLICATION FOR UPGRADE TO THERAPEUTIC OPTOMETRIST LICENSURE
## INSTRUCTION SHEET

### When to Apply for Upgrade

File this application to upgrade to Therapeutic Optometrist licensure if you

- hold a *current* Delaware Diagnostic Optometrist license
- have *completed* 40 hours of therapeutic experience
- have passed the treatment and management of ocular disease (TMOD) portion of the National Board of Examiners in Optometry (NBEO) examination

The therapeutic certification requirements are in Section 11.0 of the Board's Rules and Regulations.

If you do not hold a *current* Delaware Diagnostic Optometrist license, you must apply by internship or reciprocity.

### Requirements for All Applicants

The following are required for upgrade.

☐ Submit completed, signed and notarized *Application for Upgrade to Therapeutic Optometrist Licensure*.

☐ Enclose the upgrade fee by check or money order made payable to "State of Delaware."

☐ Complete the *Criminal History Record Check Authorization* form to request State of Delaware and Federal Bureau of Investigation criminal background checks. Follow the instructions on the form to arrange to be fingerprinted.

☐ If you passed the NBEO's TMOD examination *before 2007*, arrange for the Board office to receive an official report of your passing scores, sent *directly* from NBEO to the Board office.

- If you passed the NBEO in 2007 or later, the Board office generally will have already received your score report from NBEO. If it does not have your scores, the Board office will notify you to request a score report.
- For information about the exam and requesting score reports, see the NBEO website at www.optometry.org

☐ Arrange for the Board office to receive a letter from your supervising doctor stating that you have completed 40 hours of TMOD training under his/her supervision, sent directly from your supervising doctor to the Board office.

- Your supervising doctor must be a therapeutically-certified optometrist, a medical doctor, or an osteopathic doctor.
- If your supervising doctor is a therapeutically-certified optometrist practicing in a jurisdiction other than Delaware, submit a copy of that jurisdiction's law and regulations on the practice of optometry. The Board will review the therapeutic practice standards in the other jurisdiction to determine if they are similar to Delaware's standards. You must complete the 40 hours of TMOD Training within the 24 months before you file this upgrade application. . No clinical experience older than 24 months (prior to application) will be accepted for therapeutic licensure.

☐ If you have never been issued a U.S. Social Security Number (SSN), submit a *Request for Exemption from Social Security Number Requirement*.
*The Privacy Act of 1974, Section 7, requires the following information to be given to all applicants:* Applicants for any Delaware professional or occupational license, permit, registration or certificate (other than Gaming permits) are required to provide a U.S. SSN (29 *Del. C.* §8735(m)). The Division of Professional Regulation uses the SSN primarily to verify identity and safeguard personal information. It may also be used to enforce child support obligation (13 *Del. C.* §2216) and for other lawful purposes.

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## IDENTIFYING AND CONTACT INFORMATION

1. Full Name: _____ _____ _____
   Last/Family First Middle

2. Other Names Used: _____ _____ _____
   (Include maiden, former married names and alternate spellings.)

3. Date of Birth (month/day/year): _____ Gender: Male ☐ Female ☐

4. Have you been issued a U.S. Social Security Number? Yes ☐ No ☐ If yes, enter your SSN: _____
   If no, you must file a *Request for Exemption from Social Security Number Requirement*.

5. Mailing Address: _____

   _____ _____ _____
   City State Zip

6. Phone: _____ _____ Email: _____
   daytime evening or cell

## THERAPEUTIC CERTIFICATION REQUIREMENTS

7. Enter your current Delaware Diagnostic Optometrist license number: I2 - _____

8. Have you passed the TMOD portion of the NBEO examination? Yes ☐ No ☐

   **If you passed the NBEO examination *before 2007*, arrange for the Board office to receive an official report of your passing scores on TMOD, sent *directly* from NBEO to the Board office.**

9. Do you hold current certification to perform CPR on adults and children? Yes ☐ No ☐

   **Submit a copy (front and back) of your current CPR certification for adults and children.**

10. Have you completed 40 hours of TMOD training under the supervision of a therapeutically-certified optometrist, medical doctor or osteopathic doctor? Yes ☐ No ☐ **If yes, enter the following information about experience:**

    Enter Period of Supervised TMOD Training: From: _____ To: _____
    month/year month/year

    Supervising Doctor: _____ ☐ Physician ☐ Therapeutic Optometrist

    **Arrange for the Board office to receive a letter from your supervising doctor, sent directly from the supervising doctor to the Board office, stating that you have completed 40 hours of TMOD training under his/her supervision. If you checked *Physician*, skip to the DUTY TO REPORT section. If you checked *Therapeutic Optometrist*, continue with the next question.**

11. Where did your supervised TMOD training occur? ☐ Delaware ☐ Other Jurisdiction **If you checked *Other Jurisdiction*, enter the jurisdiction(s) and submit a copy of the jurisdiction's law and regulations on the practice of optometry:** _____

**DUTY TO REPORT**

12. To obtain a license in Delaware, you must certify that you understand that you have a ***mandatory*** obligation to file a written report with the Board of Medical Licensure and Discipline within 30 days if you have any reason to believe that a medical practitioner *other than yourself* is (or may be) guilty of unprofessional conduct as defined in 24 *Del. C.* §1731 OR that he/she is (or may be):
    - medically incompetent
    - mentally or physically unable to engage safely in the practice of medicine
    - excessively using or abusing drugs including alcohol.

    I certify that I have read and understand the provisions of 24 *Del. C.* §1730, 24 *Del. C.* §1731 and 24 *Del. C.* §1731A and that I understand my *duty to report*. Yes ☐ No ☐

13. To obtain a license in Delaware, you must certify that you understand that you have a ***mandatory*** obligation to make an immediate oral report to the Department of Services for Children, Youth and Their Families if you know of, or you suspect, child abuse or neglect under Chapter 9 of Title 16 and to follow up with any requested written reports.

    I certify that I have read and understand 16 *Del. C.* §903 and that I understand my *duty to report*. Yes ☐ No ☐

**To assure that your application is ready for Board review, the Board office must receive all of these items no later than 4:30 PM ten full working days before the Board's meeting date:**

- **Completed, signed and notarized application form**
- **Fee payment**
- **All required supporting documentation.**

**Applications that are not complete within 12 months of filing may be considered abandoned and discarded.**

## AFFIDAVIT

I certify that the information in this application is complete and true. I understand that the intentional inclusion of false or fraudulent information in this application, or the material omission of information which might have a bearing on licensure, may result in the denial of licensure and will be reported to the Attorney General for further action. I understand that the application fee is not refundable.

**Signature of Applicant:** _____Date: _____

City of _____ County of _____

Sworn to before me and subscribed in my presence this _____ day of _____, 2____

Signature of Notary: _____

SEAL

My commission expires: _____

***APPLICATIONS THAT ARE UNSIGNED, NOT NOTARIZED, INCOMPLETE OR NOT ACCOMPANIED BY THE REQUIRED FEE WILL BE REJECTED.***

# Instructions for Requesting a Criminal Background Check

***Both State of Delaware and Federal Bureau of Investigation criminal background checks are required.***

## Locations

**Kent County – Primary Facility**
State Bureau of Identification
Blue Hen Mall & Corporate Center
655 Bay Rd. Suite 1B
Dover, DE 19901
***Walk-ins accepted:*** Mon 9 am – 7 pm, Tue - Fri 9 am – 3 pm
Customer Service: (302) 739-2134

**New Castle County - Satellite Facility**
State Police Troop Two
100 LaGrange Ave
Newark, DE 19702
(Between Rts. 72 and 896 on Rt. 40)
***By appointment only***
Scheduling: (302) 739-2528 (local)
(800) 464-4357 (toll free)

**Sussex County – Satellite Facility**
Delaware State Police Troop Four
South DuPont Hwy & Shortley Rd.
Georgetown DE 19947
(Across from DelDOT & the State Service Ctr.)
***By appointment only***
Scheduling: (302) 739-2528 (local)
(800) 464-4357 (toll free)

## Applicants Residing in Delaware

1. If you are using the New Castle or Sussex Counties locations, call **(800) 464-HELP (4357)** to schedule an appointment. No appointments are needed at the Kent County location.

2. Take the completed *Authorization for Release of Information* form to one of the offices listed above with the fee of $69.00, to cover both the State of Delaware and Federal Bureau of Investigation criminal checks. Money orders and credit cards other than American Express are accepted at all locations. New Castle and Kent Counties accept cash; Sussex County does not accept cash. *Personal checks are not accepted in any county.* As fees are subject to change, contact the agency where you plan to submit your forms for current fees.

## Out-of-State Applicants

1. You can be fingerprinted by your local police agency. All types of fingerprint cards are accepted. If your local police agency cannot provide a fingerprint card, call **(302) 739-2134** to request a fingerprint card.

2. Your *Authorization for Release of Information* form and fingerprint card must be complete. If identifying information is missing (such as name, date of birth, race, sex, etc.), your form will be returned.

3. ***Mail*** the *Authorization* form, fingerprint card, and certified check or money order (*personal checks are not accepted*) for $69.00 made payable to "Delaware State Police" to:

**Delaware State Police**
**State Bureau of Identification (SBI)**
**PO Box 430**
**Dover, DE 19903-0430**

⇨***ALLOW FOUR WEEKS FOR RECEIPT OF RESULTS.***

***DO NOT SEND THE FORM OR FEE TO THE BOARD OFFICE***

Created 10/2014

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# CRIMINAL HISTORY RECORD CHECK FOR PROFESSIONAL LICENSURE APPLICANTS

## AUTHORIZATION FOR RELEASE OF INFORMATION

*Please print or type all information in black ink.*

**Check the type of license for which you are applying:**

- ☐ Adult Entertainment
- ☐ Charitable Gaming Vendor
- ☐ Chiropractic
- ☐ Dental
- ☐ Massage
- ☐ Mental Health (LPCMH, LCDP, LMFT, LAPCMH, LAMFT)
- ☐ Nursing (RN, LPN, APN)
- ☐ Nursing Home Administrator
- ☐ Occupational Therapy
- ☐ Optometry
- ☐ Pharmacy
- ☐ Physical Therapy/Athletic Trainer
- ☐ Podiatry
- ☐ Psychology
- ☐ Real Estate Appraiser (includes Appraisal Management Company)
- ☐ Speech/Hearing
- ☐ Social Work
- ☐ Texas Hold'em Individual
- ☐ Medical (Physicians, Physician Assistants, Respiratory Care Practitioners, Acupuncture Practitioners, Genetic Counselors, Polysomnographers)

**Print your current full name:**

_____ _____ _____ _____
Last Name | First Name | Middle Initial | Suffix (e.g., Jr., Sr.)

**Enter all other names you have used in the past (including, but not limited to, maiden name, former married names, alternative spellings):**

1. _____
2. _____
3. _____
4. _____

As an applicant, I authorize release of any and all information that you have concerning my **CRIMINAL HISTORY RECORD INFORMATION**. I hereby release you, your organization, the State of Delaware and others from any liability or damage which may result from furnishing this information:

**SIGNATURE OF PERSON PRINTED:** _____ **Date**: _____

Phone: Home _____ Work _____

**Mail the results of my criminal history request to:**

**Division of Professional Regulation**
**861 Silver Lake Boulevard, Suite 203**
**Dover DE 19904**
**SLC D420A**

**USE OF CRIMINAL HISTORY RECORD INFORMATION IS RESTRICTED BY LAW AND SHALL BE LIMITED TO THE PURPOSE FOR WHICH IT WAS GIVEN. MISUSE CONSTITUTES A CRIMINAL VIOLATION.**

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